IMPORTANT - READ PRIOR TO COMPLETING THE APPLICATION FORM

The Individual Volunteer Health Care Provider application form **requires two signatures upon submission**. Signatures are required in "**Section 5** - *Authorization for Release of Personal Information"* and "**Section 19** - *Signature of Agreement*."

Until this document has been signed by the DEPARTMENT, it is **NOT** a valid protection agreement.

SECTION 1 – GENERAL

[PRINT CLEARLY]

Name. Enter your first and last names.

Address. Enter mailing address.

Phone (daytime number). Enter area code and phone number.

Cell Phone Number. Enter area code and phone number, if available.

Email. Enter email address, if available. By providing us with your email address, you agree we may communicate with you by electronic mail. The VHCPP prefers to communicate with participants by electronic mail.

License. Enter the current license, certification, or registration number for your profession.

Specialty. Mark yes if being referred by the **Specialty Care Referral Network**.

Identify your Profession. Check the box identifying your profession.

Self-Query report is **REQUIRED** for professions with the red asterisks (**) and **MUST** submit the self-query report obtained from the National Practitioner Data Bank, NPDB, with a completed Individual VHCPP individual application form.

- Access the data bank web site at http://www.npdb.hrsa.gov/ select the **"FOR HEALTH CARE PROFESSIONALS"** link, then the **"HOW TO GET STARTED"** link. Follow the online instructions to complete your Self-Query. A minimal fee [less than $10.00] will be assessed for all requests.
- If you do not have access to the internet call **1-800-767-6732** for the Data Bank customer service center.
- Upon receipt of the self-query report, make a copy for your file. Submit the original report with the Individual Volunteer Health Care Provider application form to: **VHCPP, IDPH, OHDS, LUCAS STATE OFFICE BUILDING, 321 E 12TH ST, DES MOINES, IA 50319.**

SECTION 2 - HOURS & SITE LOCATION

Hours. Enter the number of hours you might provide health care services per **WEEK**. You will only be provided coverage for the hours specified. This number is not your required work hours.

Site Location. Enter the name and address information for each site location where you will provide health care services.

SECTION 3 - PERSONAL HISTORY

Personal History. Answer each question. **FOR EACH "YES" ANSWER**, a separate, signed statement giving full details, including date(s), location(s), action(s), organization(s) or parties involved, specific reason(s) and outcome(s) **MUST** be included with the application form. Read the definitions listed below before completing the personal history questions.

IMPORTANT - READ PRIOR TO COMPLETING THE APPLICATION FORM

SECTION 3 - PERSONAL HISTORY (CONTINUED)

"Ability to practice within your profession with reasonable skill and safety" means **ALL** of the following: **1)** cognitive capacity; **2)** ability to communicate with patients and other health care providers and **3)** capability to perform health care services within your profession.

"Medical condition" means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

"Chemical substances" means alcohol, legal and illegal drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of chemical substances or medical conditions may have an ongoing impact on the ability to function and practice, or has adversely affected the ability to function and practice within the past two (2) years.

"Improper use of drugs or other chemical substances" means **ANY** of the following: **1)** The use of any controlled drug, legend drug, or other chemical substance for any purpose other than as directed by a licensed health care practitioner and **2)** The use of any substance, including but not limited to, petroleum or adhesive products, nitrous oxide, and other chemical substances for mood enhancement.

"Illegal use of drugs or other chemical substances" means the manufacture, possession, distribution, or use of any drug or chemical substance prohibited by law.

SECTION 4 - PROFESSION, PATIENT GROUPS, AND HEALTH CARE SERVICES

Profession. **ONLY** complete the section applicable to **YOUR PROFESSION**.

NOTE: Above the **PHYSICIAN ASSISTANT, PA,** block, a space is provided for a supervising physician's signature. The supervising physician **MUST** sign this space signifying they have agreed to supervise the PA.

Patient groups. Each profession has up to four patient groups which may be served. For each service checked you must identify which patients groups will be served.

Services. Check the health care services you will be providing at the free clinic.

SECTION 5 - AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

Signature. Signature of applicant is **REQUIRED**.

Date. Enter date the application is signed.

SECTIONS 6 - 18 - PROTECTION AGREEMENT

These sections contain the **INDIVIDUAL VOLUNTEER HEALTH CARE PROVIDER** protection agreement.

SECTIONS 19 – SIGNATURE OF AGREEMENT

SIGNATURE of applicant is **REQUIRED**. The INDIVIDUAL VOLUNTEER HEALTH CARE PROVIDER is not protected for volunteer services provided prior to the signing of the protection agreement by the DEPARTMENT. Once fully executed, this document serves, for two years, as the protection agreement between the INDIVIDUAL VOLUNTEER HEALTH CARE PROVIDER and the DEPARTMENT. A fully signed copy will be sent to the INDIVIDUAL VOLUNTEER HEALTH CARE PROVIDER.